STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155042	A. BUILDING _____ B. WING _____	R 02/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RIDGE HEALTH INVESTORS LLC	3801 OLD BRUCEVILLE ROAD, BOX 136 VINCENNES, IN 47591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 12/7/10.

This visit was in conjunction with a PSR to the Investigation of Complaint IN00084086 and Complaint IN00084156 completed on 1/4/11.

Survey Dates: February 2, 3, and 7, 2011.

Facility number:000016
Provider number: 155042
AIM number: 100291500

Survey team: Terri Walters, RN TC
Martha Saull, RN
Elizabeth Harper, RN
Carole McDaniel ,RN
2/3/11, 2/7/11

Census bed type:
SNF: 23
SNF/NF: 93
Total: 116

Census payor type:
Medicare: 23
Medicaid: 76
Other: 17
Total: 116

Sample: 15

These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.

Quality review completed on February 9, 2011 by Bev Faulkner, RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 225} SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	{F 225}		2/18/11

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{F 225}	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to protect residents from further abuse for 1 of 2 allegations of abuse affecting 1 of 15 residents in a sample of 15 (Resident #1)and involved CNA #1 and RN #1. Findings include: The clinical record of Resident #1 was reviewed on 2/07/11 at 12:30 P.M. The 11/18/10 Minimum Data Set Assessment (MDS) identified the resident to be severely impaired in cognition with occasional urinary incontinence and requiring extensive assistance of one person. An undated "Facility Incident Reporting Form" indicated on 1/28/11 at approximately 6:00 A.M., Resident #1 was stating " I need to pee, I need to pee." and CNA #1 was heard by RN #1 to tell the resident he needed to "say please" because " I am not your (racial slur). RN #1 provided a written statement of the event later that day. Her statement included "...(Resident # 1) came out of his room and said "I have to pee, I have to pee and (CNA #1) said ' ask me and say please, don't tell me what to do. I'm not a (racial slur).' CNA #1 then proceeded to follow (Resident #1) to his room and continued to tell him to say please and she would take him to the bathroom. I heard him say please..." A "Corrective Action" form filled out by the Unit Manager on 1/28/11, as part of an investigation of the abuse indicated a verbal warning, had been issued to the RN. The supervisor statement of explanation of the problem was " You witnessed a CNA being rude and inappropriate to Resident	{F 225}		

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{F 225}	Continued From page 3 and allowed the CNA to continue Resident care until the end of the shift." The Unit Manager was interviewed on 2/07/11 at 10:45 A.M., regarding the incident. He indicated his investigation of the incident which happened at approximately 5:45 A.M., identified CNA #1 had been permitted to continue care of the resident. She took him to the bathroom and provided care for approximately 15 minutes before clocking out at 6:00 A.M., and leaving without being suspended pending investigation. He further indicated the incident had not been immediately reported to himself as supervisor and the Administrator. He indicated he had first been informed later that morning sometime between 8:00 A.M. and 9:30 A.M. He indicated the Director of Nursing (DON) at the time of the incident had terminated the CNA on 1/31/11, when the facility was first able to locate her and before she had opportunity for contact with residents. The DON statement of rationale for the termination included "Speaking to residents and failure to conduct self as an C.N.A., failure to follow the residents rights 'Free from verbal and physical abuse.' " This deficiency was cited on 12/7/10. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-28(c) 3.1-28(d)	{F 225}		
{F 226} SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit	{F 226}		2/18/11

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{F 226}	Continued From page 4 mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Abuse Prevention policies were followed regarding reporting and immediate employee suspension for 1 of 2 allegations of abuse involving 1 of 15 residents in a sample of 15. Resident #1 Findings include: An undated "Facility Incident Reporting Form" indicated on 1/28/11 at approximately 6:00 A.M., Resident #1 was stating " I need to pee, I need to pee." and CNA #1 was heard by RN #1 to tell the resident he needed to "say please" because " I am not your (racial slur). RN #1 provided a written statement of the event later that day. Her statement included "...(Resident # 1) came out of his room and said "I have to pee, I have to pee and (CNA #1) said ' ask me and say please, don't tell me what to do. I'm not a (racial slur).' CNA #1 then proceeded to follow (Resident #1) to his room and continued to tell him to say please and she would take him to the bathroom. I heard him say please..." A "Corrective Action" form filled out by the Unit Manager as part of an investigation of the abuse indicated a verbal warning had been issued to the RN. The supervisor statement of explanation of the problem was " You witnessed a CNA being rude and inappropriate to Resident and allowed the CNA to continue Resident care until the end	{F 226}		

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{F 226}	Continued From page 5 of the shift." The Unit Manager was interviewed on 2/07/11 at 10:45 A.M., regarding the incident. He indicated his investigation of the incident which happened at approximately 5:45 A.M., identified CNA #1 had been permitted to continue care of the resident. She took him to the bathroom and provided care for approximately 15 minutes before clocking out at 6:00 A.M., and leaving without being suspended pending investigation. He further indicated the incident had not been immediately reported to himself as supervisor and the Administrator. He indicated he had first been informed later that morning sometime between 8:00 A.M. and 9:30 A.M. He indicated the Director of Nursing (DON) at the time of the incident had terminated the CNA on 1/31/11, when the facility was first able to locate her and before she had opportunity for contact with residents. The DON statement of rationale for the termination included "Speaking to residents and failure to conduct self as an C.N.A., failure to follow the residents rights 'Free from verbal and physical abuse.' " The facility Abuse Prevention Policy and Procedure initiated on 10/01/2010 was reviewed on 2/07/11 at 3:30 P.M. Excerpts included: "...Our abuse prevention/intervention program may include, but is not necessarily limited to, the following:...Monitoring staff on all shifts to identify inapposite behaviors toward residents (e.g., using derogatory language, rough handling of residents, ignoring residents while giving care, directing residents who need toileting assistance to urinate or defecate in their clothing/beds, etc.)... Our	{F 226}		

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{F 226}	Continued From page 6 facility will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect that should be promptly reported or to the Director of Nursing. The Administrator should be notified immediately...Employees of this facility who have been accused of resident abuse will be suspended from duty until the results of the investigation have been reviewed by the administrator..." 3.1-28(a)	{F 226}		